AMENDED IN ASSEMBLY MAY 22, 1997

AMENDED IN ASSEMBLY APRIL 17, 1997

AMENDED IN ASSEMBLY APRIL 14, 1997

AMENDED IN ASSEMBLY APRIL 2, 1997

CALIFORNIA LEGISLATURE—1997–98 REGULAR SESSION

ASSEMBLY BILL No. 1181

Introduced by Assembly Member Escutia

February 28, 1997

An act to add Section 1374.16 to the Health and Safety Code, *and to amend Section 14016.5 of the Welfare and Institutions Code,* relating to health care.

LEGISLATIVE COUNSEL'S DIGEST

AB 1181, as amended, Escutia. Health care coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Commissioner of Corporations and makes the willful violation of these provisions subject to criminal sanction.

This bill would require every health care service plan to establish and implement procedures by which an enrollee could receive a standing referral to a specialist and by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling could receive a referral to a specialist who has expertise in treating the

condition or disease for the purpose of having the specialist coordinate the enrollee's health care. Because the bill would change the definition of an existing crime, it would impose a state-mandated local program.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services, pursuant to which benefits are provided to public assistance recipients and certain other low-income persons.

The bill would provide that the above described procedures shall apply to Medi-Cal beneficiaries enrolled in a health care service plan.

Existing law requires a county to ensure that each Medi-Cal or Aid to Families with Dependent Children (AFDC) program applicant or beneficiary who resides in the area served by a managed health care plan or pilot program in which beneficiaries can enroll, personally attends a presentation about the managed care and fee-for-service options available regarding methods of receiving Medi-Cal benefits. Existing law requires that the presentation provide the name, address, and telephone number of each primary care provider, by specialty, or clinic participating in each managed health care plan, pilot program, or fee-for-service case management provider option.

This bill would require that this information be presented first under geographic area designations, and then in alphabetical order of the name of each primary care provider and clinic.

Existing law sets forth procedures under which an applicant or beneficiary is generally required as a condition of coverage to choose between 2 health care options, obtain a Medi-Cal card and receive services from individual providers who provide services to Medi-Cal beneficiaries or enroll in a prepaid managed health care plan, pilot project, or fee-for-service case management provider option. These provisions require an applicant or beneficiary to choose a primary care provider under various circumstances.

This bill would, in certain instances where the provisions apply to a primary care provider, extend the application to a clinic.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1374.16 is added to the Health and Safety Code, to read:

1374.16. (a) Every health care service plan shall establish and implement a procedure by which an enrollee may receive a standing referral to a specialist. The procedure shall provide for a standing referral to a specialist if the primary care physician determines in consultation with the specialist, if any, *and the plan medical director or his or her designee,* that an enrollee needs continuing care from a specialist. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, the specialist, and the enrollee. The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, or require that the specialist provide the primary care physician with regular reports on the health care provided to the enrollee.

(b) Every health care service plan shall establish and implement a procedure by which an enrollee with a condition or disease that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling may receive a referral to a specialist who has expertise in treating the condition or disease for the purpose of having the specialist coordinate the enrollee's health care. *The referral shall be made if the primary care physician, in consultation with the specialist if any, and the plan medical director or his or her designee determines that*

this specialized medical care is medically necessary for the enrollee. The referral shall be made pursuant to a treatment plan approved by the health care service plan in consultation with the primary care physician, specialist, and enrollee. After the referral is made, the specialist shall be authorized to provide health care services to the enrollee in the same manner as the enrollee's primary care physician, subject to the terms of the treatment plan.

(c) The determinations described in subdivisions (a) and (b) shall be made within ~~72 hours after a~~ *three business days of the date the* request for the determination is made by the enrollee or the enrollee's primary care physician and all appropriate medical records and other items of information necessary to make the determination are provided. Once a determination is made, the referral shall be made within ~~96 hours after the determination~~ *four business days of the date the proposed treatment plan is submitted to the plan medical director or his or her designee*.

(d) Subdivisions (a) and (b) do not require a health care plan to permit an enrollee to elect referral to a specialist who is not employed by or under contract with the health care service plan to provide health care services to its enrollees, *unless there is no specialist within the plan network that is appropriate to provide treatment to the enrollee*.

(e) The procedures established pursuant to this section shall apply to every health care service plan contract entered into, amended, or renewed on or after January 1, 1998.

(f) Notwithstanding any other law, this section shall apply to Medi-Cal beneficiaries enrolled in a health care service plan *and the treatment plan developed pursuant to this section shall be consistent with federal and state medicaid requirements. Nothing in this section is intended to alter or abrogate any other requirements of federal or state law with regard to medicaid*.

SEC. 2. *Section 14016.5 of the Welfare and Institutions Code is amended to read:*

14016.5. (a) At the time of determining or redetermining the eligibility of a Medi-Cal or aid to families with dependent children (AFDC) applicant or beneficiary who resides in an area served by a managed health care plan or pilot program in which beneficiaries may enroll, each applicant or beneficiary shall personally attend a presentation at which the applicant or beneficiary is informed of the managed care and fee-for-service options available regarding methods of receiving Medi-Cal benefits. The county shall ensure that each beneficiary or applicant attends this presentation.

(b) The health care options presentation described in subdivision (a) shall include all of the following elements:

(1) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in the fee-for-service sector.

(2) Each beneficiary or eligible applicant shall be provided with the name, address, ~~and~~ telephone number, *and specialty, if any,* of each primary care provider, ~~by specialty, or clinic~~ *and each clinic,* participating in each prepaid managed health care plan, pilot project, or fee-for-service case management provider option. *This information shall be presented first under geographic area designations and then in alphabetical order of the name of the primary care provider and clinic.* The name, address, and telephone number of each specialist participating in each prepaid managed care health plan, pilot project, or fee-for-service case management provider option shall be made available by either contacting the health care options contractor or the prepaid managed care health plan, pilot project, or fee-for-service case management provider.

(3) Each beneficiary or eligible applicant shall be informed that he or she may choose to continue an established patient-provider relationship in a managed care option, if his or her treating provider is a primary care provider *or clinic* contracting with any of the prepaid managed health care plans, pilot projects, or fee-for-service case management provider options

available, has available capacity, and agrees to continue to treat that beneficiary or applicant.

(4) In areas specified by the director, each beneficiary or eligible applicant shall be informed that if he or she fails to make a choice, or does not certify that he or she has an established relationship with a primary care provider or clinic, he or she shall be assigned to, and enrolled in, a prepaid managed health care plan, pilot projects, or fee-for-service case management provider.

(c) No later than 30 days following the date a Medi-Cal or AFDC beneficiary or applicant is determined eligible, the beneficiary or applicant shall indicate his or her choice in writing, as a condition of coverage for Medi-Cal benefits, of either of the following health care options:

(1) To obtain benefits by receiving a Medi-Cal card, which may be used to obtain services from individual providers, that the beneficiary would locate, who choose to provide services to Medi-Cal beneficiaries.

The department may require each beneficiary or eligible applicant, as a condition for electing this option, to sign a statement certifying that he or she has an established patient-provider relationship, or in the case of a dependent, the parent or guardian shall make that certification. This certification shall not require the acknowledgment or guarantee of acceptance, by any indicated Medi-Cal provider or health facility, of any beneficiary making a certification under this section.

(2) (A) To obtain benefits by enrolling in a prepaid managed health care plan, pilot program, or fee-for-service case management provider that has agreed to make Medi-Cal services readily available to enrolled Medi-Cal beneficiaries.

(B) At the time the beneficiary or eligible applicant selects a prepaid managed health care plan, pilot project, or fee-for-service case management provider, the department shall, when applicable, encourage the beneficiary or eligible applicant to also indicate, in writing, his or her choice of primary care provider *or clinic* contracting with the selected prepaid managed

health care plan, pilot project, or fee-for-service case management provider.

(d) (1) In areas specified by the director, a Medi-Cal or AFDC beneficiary or eligible applicant who does not make a choice, or who does not certify that he or she has an established relationship with a primary care provider *or clinic* shall be assigned to and enrolled in an appropriate Medi-Cal managed care plan, pilot project, or fee-for-service case management provider providing service within the area in which the beneficiary resides.

(2) If it is not possible to enroll the beneficiary under a Medi-Cal managed care plan or pilot project or a fee-for-service case management provider because of a lack of capacity or availability of participating contractors, the beneficiary shall be provided with a Medi-Cal card and informed about fee-for-service primary care providers who do all of the following:

(A) The providers agree to accept Medi-Cal patients.

(B) The providers provide information about the provider's willingness to accept Medi-Cal patients as described in Section 14016.6.

(C) The providers provide services within the area in which the beneficiary resides.

(e) If a beneficiary or eligible applicant does not choose a primary care provider or clinic or does not select any primary care provider who is available, the managed health care plan, pilot project, or fee-for-service case management provider that was selected by or assigned to the beneficiary shall ensure that the beneficiary selects a primary care provider or clinic within 30 days after enrollment or is assigned to a primary care provider within 40 days after enrollment.

(f) (1) The managed care plan shall have a valid Medi-Cal contract, adequate capacity, and appropriate staffing to provide health care services to the beneficiary.

(2) The department shall establish standards for all of the following:

(A) The maximum distances a beneficiary is required to travel to obtain primary care services from the managed care plan, fee-for-service managed care

provider, or pilot project in which the beneficiary is enrolled.

(B) The conditions under which a primary care service site shall be accessible by public transportation.

(C) The conditions under which a managed care plan, fee-for-service managed care provider, or pilot project shall provide nonmedical transportation to a primary care service site.

(3) In developing the standards required by paragraph (2), the department shall take into account, on a geographic basis, the means of transportation used and distances typically traveled by Medi-Cal beneficiaries to obtain fee-for-service primary care services and the experience of managed care plans in delivering services to Medi-Cal enrollees. The department shall also consider the provider's ability to render culturally and linguistically appropriate services.

(g) To the extent possible, the arrangements for carrying out subdivision (d) shall provide for the equitable distribution of Medi-Cal beneficiaries among participating managed care plans, fee-for-service case management providers, and pilot projects.

(h) If, under the provisions of subdivision (d), a Medi-Cal beneficiary or applicant does not make a choice or does not certify that he or she has an established relationship with a primary care provider *or clinic*, the person may, at the option of the department, be provided with a Medi-Cal card or be assigned to and enrolled in a managed care plan providing service within the area in which the beneficiary resides.

(i) Any Medi-Cal or AFDC beneficiary who is dissatisfied with the provider or managed care plan, pilot project, or fee-for-service case management provider shall be allowed to select or be assigned to another provider or managed care plan, pilot project, or fee-for-service case management provider.

(j) The department or its contractor shall notify a managed care plan, pilot project, or fee-for-service case management provider when it has been selected by or assigned to a beneficiary. The managed care plan, pilot

project, or fee-for-service case management provider that has been selected by, or assigned to, a beneficiary, shall notify the primary care provider or clinic ~~than~~ *that* it has been selected or assigned. The managed care plan, pilot project, or fee-for-service case management provider shall also notify the beneficiary of the managed care plan, pilot project, or fee-for-service case management provider or clinic selected or assigned.

(k) (1) The department shall ensure that Medi-Cal beneficiaries eligible under Title XVI of the Social Security Act are provided with information about options available regarding methods of receiving Medi-Cal benefits as described in subdivision (c).

(2) (A) The director may waive the requirements of subdivisions (c) and (d) until a means is established to directly provide the presentation described in subdivision (a) to beneficiaries who are eligible for the federal Supplemental Security Income for the Aged, Blind, and Disabled Program (Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code).

(B) The director may elect not to apply the requirements of subdivisions (c) and (d) to beneficiaries whose eligibility under the Supplemental Security Income program is established before January 1, 1994.

(*l*) In areas where there is no prepaid managed health care plan or pilot program which has contracted with the department to provide services to Medi-Cal beneficiaries, and where no other enrollment requirements have been established by the department, no explicit choice need be made, and the beneficiary or eligible applicant shall receive a Medi-Cal card.

(m) The following definitions contained in this subdivision shall control the construction of this section, unless the context requires otherwise:

(1) ''Applicant,'' ''beneficiary,'' and ''eligible applicant,'' in the case of a family group, means any person with legal authority to make a choice on behalf of dependent family members.

(2) ‘‘Fee-for-service case management provider’’ means a provider enrolled and certified to participate in the Medi-Cal fee-for-service case management program the department may elect to develop in selected areas of the state with the assistance of and in cooperation with California physician providers and other interested provider groups.

(3) ‘‘Managed health care plan’’ and ‘‘managed care plan’’ mean a person or entity operating under a Medi-Cal contract with the department under this chapter or Chapter 8 (commencing with Section 14200) to provide, or arrange for, health care services for Medi-Cal beneficiaries as an alternative to the Medi-Cal fee-for-service program that has a contractual responsibility to manage health care provided to Medi-Cal beneficiaries covered by the contract.

(n) This section shall be implemented in a manner consistent with any federal waiver required to be obtained by the department in order to implement this section.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Notwithstanding Section 17580 of the Government Code, unless otherwise specified, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

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